CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

December 4, 2001

H.R. 3046
Medicare Regulatory and Contracting Reform Act of 2001

As ordered reported by the House Committee on Energy and Commerce on October 31, 2001

SUMMARY

The Medicare Regulatory and Contracting Reform Act of 2001 would require the Centers for Medicare and Medicaid Services (CMS) to modify how Medicare regulations and policies are developed, communicated, and enforced, and would modify the procedures used to resolve disputes involving payment for services covered by Medicare. The bill would transfer certain administrative law judges from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS). It would change the procedures by which Medicare makes contracts with entities to process and pay claims, and it would place new requirements on those contractors. It would require the Secretary of HHS to conduct several demonstrations, and would require the completion of several studies and reports.

The bill would also affect direct spending by changing procedures for determining whether a service is covered by Medicare, and by appropriating additional funds to the Medicare Integrity Program.

CBO estimates that implementing H.R. 3046 would cost $59 million in 2002 and $1.4 billion over the 2002-2006 period from appropriated funds. CBO also estimates that implementing the bill would increase direct spending by $27 million in 2002, $1.3 billion over the 2002-2006 period, and $5.4 billion over the 2002-2011 period. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

H.R. 3046 would preempt state and local laws governing liability for Medicare administrative contractors in some cases. This preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would prevent the application of state laws. However, because the preemption would not require state or local governments to take any specific action, it would impose no costs on those

governments. Other provisions of the bill would have no significant effect on the budgets of state, local, or tribal governments. H.R. 3046 contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

Table 1 shows the estimated authorization levels and outlays for Medicare administrative expenses under current law and under H.R. 3046. Assuming appropriation of the estimated amounts, CBO estimates that implementing H.R. 3046 would cost $59 million in 2002 and $1.4 billion over the 2002-2006 period. The table also shows the estimated effect of H.R. 3046 on direct spending, a total of $1.3 billion over the 2002-2006 period. The costs of this legislation fall within budget function 570 (Medicare).

TABLE 1. ESTIMATED BUDGETARY IMPACT OF H.R. 3046

	By Fiscal Year, in Millions of Dollars					
	2001	2002	2003	2004	2005	2006
SPENDING SUBJECT TO APPROPRIATION						
Spending for Medicare Administrative Costs Under Current Law						
Estimated Budget Authority [a]	3,352	3,500	3,646	3,797	3,955	4,118
Estimated Outlays	3,321	3,464	3,631	3,757	3,913	4,074
Proposed Changes						
Estimated Authorization Level	0	65	416	347	264	318
Estimated Outlays	0	59	381	354	273	312
Spending for Medicare Administrative Costs Under H.R. 3046						
Estimated Authorization Level [a]	3,352	3,565	4,062	4,144	4,219	4,436
Estimated Outlays	3,321	3,523	4,012	4,111	4,186	4,386
DIRECT SPENDING						
Medicare Spending Under Current Law [b]						
Estimated Budget Authority	214,473	225,915	240,076	255,769	278,493	294,073
Estimated Outlays	214,114	225,933	239,855	256,065	278,411	293,843
Proposed Changes						
Estimated Budget Authority	0	27	131	243	385	554
Estimated Outlays	0	27	122	243	385	554
Medicare Spending Under H.R. 3046 [b]						
Estimated Budget Authority	214,473	225,942	240,207	256,012	278,878	294,627
Estimated Outlays	214,114	225,960	239,977	256,308	278,796	294,397

a. Budget authority and outlays for 2001 are the amounts appropriated and spent that year.
b. Includes direct spending for benefits and administrative costs less premium receipts.

BASIS OF ESTIMATE

For this estimate, CBO assumes that the legislation would be enacted this fall and that estimated amounts would be appropriated each year.

Spending Subject to Appropriations

Contracting Reform. Under current law, CMS contracts with fiscal intermediaries and carriers to process and pay claims, to educate providers regarding Medicare billing policy, and for other purposes. This bill would change the activities required of contractors and the methods by which CMS enters into contracts and oversees the activities of contractors. CBO estimates that these provisions would increase the cost of administering contracts and the total amount CMS spends on contracts by $35 million in 2002 and $1.2 billion over the 2002-2006 period.

Contracting Changes. H.R. 3046 would direct CMS to provide incentives to contractors who meet or exceed certain performance standards. Based on information furnished by CMS, we estimate that the incentive payments would total 3 percent of operating payments to contractors, or about $233 million over the 2002-2006 period.

H.R. 3046 would require CMS to competitively bid contracts with fiscal intermediaries and carriers at least every five years. CBO expects that an additional 3-5 full-time-equivalent employees (FTEs) at the GS-12 level would be needed throughout the period to write new competitively-bid contracts. The estimate assumes that about one-quarter of the contracts would be awarded to a nonincumbent bidder, and that it would cost about $2 million to transition between contractors. CBO estimates that implementing this provision would cost about $54 million over the 2002-2006 period.

Contractor Oversight. In addition, the bill would direct the Medicare program to measure the payment error rates for individual contractors, which are believed to indicate how well providers understand proper Medicare billing procedures, with the intent of identifying contractors who have achieved high levels of provider education. This provision would expand current practice, which is to calculate system-wide error rates. The bill would also expand the requirement for contractors to monitor the accuracy of information given to providers and the timeliness of contractors' processing of providers' enrollment applications. CBO estimates that complying with these provisions would cost about $30 million over the 2002-2006 period.

New Contractor Activities. The bill would require contractors to respond to written requests for guidance within 45 days of receipt, and would make that response binding on the Medicare program. We expect that contractors would receive 50 percent more written

requests under H.R. 3046 than they would under current law, with each request costing $15 dollars to process in 2002. This, plus the requirement that contractors respond to those requests within 45 days, would require contractors to hire additional employees. CBO estimates that implementing these provisions would cost $11 million in 2002 and $76 million over the 2002-2006 period.

Beginning in July 2003, the bill would require contractors, upon request of a beneficiary or provider, to make a determination about whether Medicare will cover a particular service or item before that service is furnished. The contractor would be required to conduct a medical review and to make the coverage decision within 45 days. CBO estimates that contractors would make about 100,000 determinations a year at an average cost of about $100 per determination (at 2003 prices). We estimate the cost of administering this program would total $35 million over the 2002-2006 period.

The bill would require contractors to create a system by which providers may resubmit claims originally submitted with errors or omissions without having to pursue payment via the appeals process. CBO estimates the cost of developing and operating systems to process these resubmitted claims would total $5 million in 2002 and $46 million over the 2002-2006 period.

The bill would also require contractors to give providers or beneficiaries, upon request, a summary of the clinical and scientific evidence used in making a determination. CBO estimates the cost of making available scientific and clinical evidence on determinations would total $686 million over the 2002-2006 period.

Appeals Reform. H.R. 3046 would change the processes by which Medicare adjudicates appeals by providers of payment denials and conducts compliance actions against providers. The bill would delay the date by which CMS is required to implement certain provisions of the Beneficiary Improvement and Protection Act and modify other provisions. It would also create a new mechanism for individuals to challenge National Coverage Determinations (NCDs.) CBO estimates that implementing these provisions would cost $8 million in 2002 and $114 million over the 2002-2006 period.

Administrative Law Judge Transfer. The bill would transfer certain administrative law judges (ALJs) from the Social Security Administration to the Department of Health and Human Services and would permit the Secretary to hire more ALJs. CBO estimates that the costs of planning and implementing the transfer, adding ALJs, and providing the ALJs with additional training on Medicare issues would be $1 million in 2002 and would total $39 million over the 2002-2006 period.

Standardization of Compliance and Appeals Actions. The bill would also standardize existing policies regarding the use of random and non-random prepayment review, the use

of extrapolation in the case of overpayments, and the offering of repayment plans in the case of overpayment. In addition, H.R. 3046 would create procedures by which appellants may petition for expedited access to judicial review in federal district court in certain circumstances. CBO estimates that implementing those provisions would cost $34 million over the 2002-2006 period. These provisions would require CMS to make changes to current appeals and compliance systems but would not change the conditions under which Medicare would make payments to providers. Therefore, CBO estimates that these provisions would have no effect on direct spending.

National Coverage Determinations. H.R. 3046 would also establish a process for seeking exceptions to national coverage determinations under special medical circumstances. In general, new medical technologies are integrated into existing Medicare payment systems as soon as they are approved by the Food and Drug Administration. However, in certain instances, breakthrough technologies that are clinically different from existing treatment options require a more detailed examination, either at the local level by Medicare contractors, or through an NCD issued by CMS.

Current law provides for a process by which Medicare-eligible individuals seeking coverage of a service excluded by an NCD can appeal that decision. Such an appeal would be reviewed by the Departmental Appeals Board (DAB) of the Department of Health and Human Services. If the DAB determines that there is inadequate information to support the validity of an NCD, it can permit the taking of evidence to evaluate the reasonableness of the NCD. However, CMS has not yet established a formal appeals process for NCDs, and no appeals have been filed to date.

In addition to the current NCD appeals process, H.R. 3046 would require the Secretary to establish a process whereby Medicare-eligible individuals may request an exception, due to their special medical circumstances, to an NCD that has the effect of denying coverage for items and services for the treatment of a serious or life-threatening condition. Furthermore, these special medical circumstances must not have been considered during the initial NCD process. Each request would be reviewed by an independent panel of physicians or other health care professionals. If the panel supports the request for an exception, the NCD would not be applied by any Medicare contractor with respect to treatment for that individual.

CBO assumes that the two appeals process are not perfect substitutes. Specifically, CBO assumes that some individuals who would not appeal an NCD under current law would request an exception to an NCD under the procedures outlined in H.R. 3046. CBO estimates that this provision would result in an additional 3,000 requests for exceptions above and beyond the existing NCD appeals process beginning in 2003. CBO estimates that adjudicating these requests for exceptions, including assembling panels of physicians, would cost $6 million over the 2002-2006 period. (The additional claims payments that would result from this process would be direct spending and are discussed later in this estimate.)

Demonstrations and New Program Areas. H.R. 3046 would direct CMS to expand its programs to educate beneficiaries and providers. CBO estimates that implementing these provisions would cost $6 million in 2002 and $35 million during the 2002-2006 period.

The bill would direct CMS to implement a three-year outreach demonstration in at least six locations throughout the United States. The program would involve the deployment of Medicare specialists to local Social Security Administration offices to provide beneficiaries assistance and advice regarding the Medicare program. CBO estimates that the costs of the demonstration, which would include the rental of office space, salaries for Medicare specialists, and travel, moving, and administrative expenses, would total $4 million over the 2002-2006 period.

H.R. 3046 would require CMS to designate a person to act as a liaison between providers and Medicare and to respond to providers' complaints. CBO assumes that in order to comply with this provision, this person would require the aid of several staff members. CBO estimates the cost of implementing this provision would be $4 million in 2002 and $31 million over the 2002-2006 period.

Development of Policies, Procedures, and Time Lines. H.R. 3046 would require CMS to develop new policies, procedures, and time lines with regard to the issuance of regulations and documentation guidelines for evaluation and management services. CBO estimates the cost of implementing these provisions would be $10 million in 2002 and $38 million during the 2002-2006 period.

Final Regulations. The bill would require CMS to create a time line for publishing final regulations and would limit publication of new regulations to once a month. There currently are 22 “interim final rules”; the bill would require CMS to make those rules final, and would require CMS to finalize all future regulations. We estimate that CMS would need to hire an additional 3 to 5 people, at the GS-11 level or higher, to comply with the requirement to finalize all future interim regulations and to produce the required reports. CBO estimates the cost of implementing these provisions would be $9 million in 2002 and $19 million during the 2002-2006 period.

Documentation Guidelines for Evaluation and Management (E&M) Services. H.R. 3046 would restrict CMS from implementing new documentation guidelines for evaluation and management services until several conditions have been met. Those conditions include:

- Establishing plans to improve the guidelines;

- Completing pilot projects to test modifications to the guidelines;

- Educating providers about the guidelines; and

- Consulting providers during the entire process of testing and establishing the guidelines.

CMS currently has E&M guidelines in place, and the bill would not require changes in those guidelines. CBO assumes that CMS will attempt to update those guidelines during the next few years, because both CMS and provider groups have expressed interest in doing so. The new procedural requirements would increase the cost of developing and implementing new E&M guidelines. Establishing new guidelines for E&M documentation would require the hiring of at least two FTEs for the administration of the pilot projects, for outreach to providers, and for consultation with providers. CBO further estimates that CMS would conduct at least three pilot projects, with each project costing around $1 million per year, and that the studies and reports required by these provisions would cost another $1 million.

Direct Spending

H.R. 3046 would change the conditions under which Medicare would pay for services, create a process to establish whether an item or service is covered prior to a beneficiary receiving the service, and create mechanisms by which previously excluded services would be provided in special medical circumstances. The bill would also appropriate funds to the Medicare Integrity Program.[1] CBO estimates that implementing H.R. 3046 would increase direct spending by $27 million in 2002, $1.3 billion over the 2002-2006 period, and $5.4 billion over the 2002-2011 period.

In general, if a provider is not certain whether Medicare will pay for a service or item in a particular case, there is no process under current law that enables the provider or beneficiary to find out in advance whether Medicare will pay for that service or item. In such cases, the provider may request that the beneficiary sign an advanced beneficiary notice (ABN) by which the beneficiary accepts responsibility for paying for the service if Medicare denies payment. (The provider is prohibited from charging the beneficiary if the beneficiary does not sign an ABN and Medicare subsequently denies payment.)

The bill would authorize the Secretary to specify services for which the provider or beneficiary may request a coverage determination before a service is furnished. Upon receipt of such a request, the bill would require the contractor to conduct a medical review and issue a decision within 45 days.

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1. Funds appropriated by an authorizing bill are considered direct spending.

CBO estimates that contractors would process about 100,000 requests for prior determination each year, and that half of those requests would be approved. CBO assumes that:

- About three-quarters of the approved requests would involve beneficiaries who, under current law, would choose the lower-priced service when offered the choice of a lower-priced service that Medicare is known to cover and a higher-priced service involving an ABN; in such cases, the new process would result in the use of higher-priced services.

- About one-quarter of the approved requests would involve beneficiaries who, under current law, would decline a relatively high-cost service when asked to sign an ABN; in such cases, the new process would result in the use of additional services.

- Very few requests would involve beneficiaries who, under current law, would sign an ABN and receive a service for which Medicare coverage is uncertain.[2]

For beneficiaries who would receive a lower-priced service under current law, the estimate assumes there would be a difference of about $250, on average, between the services furnished under current law and services furnished following approval for Medicare payment; the average added cost for beneficiaries who would decline a service under current law would be $500, we estimate. Those amounts are in 2003 prices, and include the cost of additional visits for beneficiaries who return to a provider after receiving approval for Medicare payment. CBO estimates that the cost of complying with this provision would be $187 million over the 2002-2011 period.

Under current law, relatives of beneficiaries cannot receive payments from Medicare for the provision of items or services to that beneficiary. H.R. 3046 would eliminate that restriction for relatives who provide care to beneficiaries in rural areas. CBO expects that this provision would have a particularly strong impact in the area of home health care—increasing spending on home health care by an estimated 2 percent—because some care givers would become employed by home health agencies to get paid for the care that they currently provide without remuneration. CBO estimates the cost of implementing this provision would be $27 million in 2002 and $4.6 billion over the 2002-2011 period.

The bill would allow beneficiaries to appeal national coverage determinations based on their individual medical circumstances. CBO estimates that this provision would result in an additional 3,000 requests for exceptions above and beyond the existing NCD appeals process, beginning in 2003. We estimate that the cost of paying claims related to these exceptions would not increase direct spending in 2002, but would increase direct spending by $376 million over the 2002-2011 period.

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2. The vast majority of ABNs are for low-cost items and services (the average payment for approved services is about $18). CBO believes that beneficiaries are unlikely to request prior determination and wait up to 45 days for an answer for such low-cost services.

H.R. 3046 would appropriate $35 million a year in additional funds to the Medicare Integrity Program beginning in fiscal year 2003. CBO estimates this provision would increase direct spending by $306 million over the 2002-2011 period.

Under current law, if a beneficiary dies after receiving services from a provider who does not accept assignment (that is, for all services furnished to Medicare beneficiaries, agree to accept payment at Medicare rates as payment in full), the provider may not appeal a denial of payment. The bill would permit those providers to make such appeals. CBO estimates that enacting this provision would result in about 2,000 denials being reversed and paid each year. We estimate that this provision would not have a significant effect on spending in 2002, and would increase spending by $5 million over the 2002-2011 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The table below shows the effect of H.R. 3046 on direct spending. For pay-as-you-go purposes, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars									
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Changes in outlays	27	122	243	385	554	629	713	807	912	1,044
Changes in receipts	Not applicable									

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 3046 would preempt state and local laws governing liability for Medicare administrative contractors in some cases. This preemption would be an intergovernmental mandate as defined in UMRA because it would prevent the application of state laws. However, because the preemption would not require the state or local governments to take any specific action, it would impose no costs on those governments. Other provisions of the bill would have no significant effect on the budgets of state, local, or tribal governments.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

H.R. 3046 contains no private-sector mandates as defined in UMRA.

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